GEORGIA DEPARTMENT OF COMMUNITY HEALTH

OPTUMRx

Atypical Antipsychotic Prior Authorization Request Form
Fee-for-Service Medicaid/PeachCare for Kids
PHONE #: 866-525-5827
FAX #: 888-491-9742

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed. **Please complete one form per member.**

MEMBER Last Name	**MEMBER First Name**
MEMBER ID number	**MEMBER Date of Birth** -- --
PRESCRIBER Last Name	**PRESCRIBER First Name**
PRESCRIBER NPI#	
PRESCRIBER Phone	**PRESCRIBER Fax**
PRESCRIBER Address	

Medication(s) Requested:_____**Strength:**_____**Directions:** _____

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Is this a tapering off dose for discontinuation? ☐ Yes ☐ No **Dosage Form:** _____ **Compound** ☐ Yes ☐ No

What is the member's diagnosis? ☐ Depressive Episodes of Bipolar Disorder ☐ Mixed or Manic Episodes of Bipolar Disorder ☐ Schizophrenia/Schizoaffective Disorder ☐ Suicidal Behavior associated with Schizophrenia/Schizoaffective Disorder ☐Treatment-Resistant Schizophrenia/Schizoaffective Disorder
☐ Pervasive Developmental Disorder (PDD)/Autism/Irritability associated with Autism/PDD ☐ Major Depressive Disorder
☐ Treatment-Resistant Major Depressive Disorder ☐ Major Depressive Disorder with Psychosis ☐ Chronic Aggression
☐ Oppositional Defiant Disorder ☐ Tourette's Syndrome ☐ Tics
☐ Other (specify): _____

Is the member being referred to a psychiatrist and awaiting an appointment? ☐ Yes ☐ No
Date of appointment:_____ **Psychiatrist:**_____

What is the member's age in years? ☐ ≥18 ☐ 10-17 ☐ 6-9 ☐ 5 ☐ <5

Is there a monitoring plan/will the member be monitored for evaluating safety and effectiveness of the medication?
☐ Yes ☐ No

If the member is younger than FDA-approved age for medication(s) requested, please complete Section E (page 3).

Medication Generic Name (Brand Name)	Under FDA-Approved Age
Aripiprazole (Abilify/Abilify Discmelt)	<6 years of age for autism/PDD irritability/Tourette's; <10 years of age for bipolar; <13 years of age for schizophrenia; <18 years of age for MDD
Aripiprazole long-acting injection (Abilify Maintena, Aristada)	<18 years of age
Brexpiprazole (Rexulti)	<18 years of age
Clozapine (Clozaril, FazaClo, Versacloz)	<18 years of age
Iloperidone (Fanapt)	<18 years of age
Ziprasidone (Geodon)	<18 years of age
Paliperidone (Invega)	<12 years of age
Paliperidone long-acting injection (Invega Sustenna, Invega Trinza)	<18 years of age
Lurasidone (Latuda)	<18 years of age
Risperidone (Risperdal/Risperdal M-Tab)	<5 years of age for autism/PDD irritability; <10 years of age for other diagnoses

Risperidone long-acting injection (Risperdal Consta)	<18 years of age
Asenapine (Saphris)	<10 years of age
Quetiapine immediate-release (Seroquel)	<10 years of age
Quetiapine extended-release (Seroquel XR)	<18 years of age for MDD; <13 years for schizophrenia; <10 years for bipolar
Olanzapine/fluoxetine (Symbyax)	<18 years of age
Olanzapine (Zyprexa/Zyprexa Zydis)	<13 years of age
Olanzapine long-acting injection (Zyprexa Relprevv)	<18 years of age

NOTE: Section A or B must be completed.

CHECK ONE *OR* B

☐ **A. <u>The member has been established on the requested medication</u>**

1. How long has the member been taking the requested medication? ☐ <2 weeks ☐ ≥2 weeks
2. Has the member shown improvement in symptoms while on the requested medication? ☐ Yes ☐ No
   If yes, please check one or more boxes below for areas of improvement:
   ☐ delusions ☐ excitement ☐ conceptual disorganization
   ☐ grandiosity ☐ hostility ☐ hallucinatory behavior
   ☐ suspiciousness/persecution ☐ blunted affect ☐ emotional withdrawal
   ☐ passive/apathetic social withdrawal ☐ poor rapport
   ☐ difficulty in abstract thinking ☐ lack of spontaneity and flow of conversation
   ☐ stereotyped thinking ☐ suicidal thoughts ☐ depressive symptoms
   ☐ other_____

☐ **B. <u>The member has never taken the requested medication</u>**

1. Which preferred medication(s) has the member tried? (check all that apply)
   ☐ Abilify Dates: _____ ☐ Latuda Dates: _____ ☐ Olanzapine Dates: _____ ☐ Risperidone Dates: _____ ☐ Quetiapine IR Dates: _____ ☐ Ziprasidone Dates: _____
   ☐ Olanzapine/Fluoxetine Dates: _____ ☐ None
2. Reason preferred agents are not appropriate for this member. (complete for each applicable drug in the following table)

Drug	Reason inappropriate choice for member
Abilify	
Latuda	
Olanzapine	
Risperidone	
Quetiapine IR	
Ziprasidone	

3. For Abilify, Rexulti, Seroquel XR, Symbyax/olanzapine/fluoxetine (for major depressive disorder only): Reason antidepressant monotherapy is not adequate for this member. (complete for each drug/class)

Drug	List medication name, response, and dates of therapy
SNRIs (desvenlafaxine [Pristiq], duloxetine [Cymbalta], venlafaxine [Effexor/XR]	
SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluvoxamine [Luvox], fluoxetine [Prozac], paroxetine [Paxil], or sertraline [Zoloft])	
Other Antidepressants (bupropion, mirtazapine, trazodone; list may not be all inclusive)	

CHECK IF APPLICABLE

☐ **C. An orally disintegrating dosage formulation or non-preferred solution is being requested.**

1. What prevents the member from taking the regular oral dosage form?
   ☐ Dysphagia ☐ Compliance monitoring required
   ☐ Other (specify):_____

☐ **D. Abilify Maintena, Aristada, Risperdal Consta, Invega Sustenna, Invega Trinza or Zyprexa Relprevv is requested.**

1. Has the member tried oral Abilify (if Abilify Maintena or Aristada is being requested), oral risperidone or oral Invega (if Risperdal Consta is being requested), oral Invega, oral risperidone, or Risperdal Consta (if Invega Sustenna is being requested), Invega Sustenna (if Invega Trinza is being requested) or oral Zyprexa (if

Zyprexa Relprevv is being requested) or does the member have a history of noncompliance with oral medications and is unable to receive a trial of the appropriate oral atypical antipsychotic before starting long-acting therapy with injection or is the member unable to swallow or use orally disintegrating tablets?
☐ Yes Date of last therapy: _____ ☐ No

2. Is the prescribing physician a psychiatrist or has a psychiatrist been consulted?
☐ Yes ☐ No
3. Where will the medication be administered?
☐ Home health or other outpatient pharmacy setting by a trained health care professional
☐ Long-term care facility
☐ CSB (Community Service Board health center)
☐ Physician's office or clinic**
☐ Other (specify):_____
** If you are requesting for authorization for administration in a physician's office or clinic other than a CSB, please go to the Registered User portion of the Georgia Health Partnership website at www.mmis.georgia.gov/portal to request a PA from Physician Services.

Section E: In the space below, please provide letter of medical necessity and any additional information you deem clinically relevant in evaluating the prior authorization request.

Physician Signature: _____

Contact Person:_____ **Phone:**_____